HASKELL
CORPORATION

EMPLOYEE REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date Reported: _____

Date of Injury: _____ Time of Injury: _____

Supervisor: _____ Client / Location: _____

Witness(es):

_____

Nature of Injury/Condition:

_____

Description of Injury [Body Part(s) Injured]:

_____

Brief Narrative Description of the Incident:

I, hereby acknowledge my declination of medical treatment and/or observation offered to me by_____for the injury or illness reported on _____. I recognize that signing this declination does not necessarily impact my later eligibility for Workers' Compensation benefits as subject to statute and insurer review.

At this time, I acknowledge that my supervisor/employer, in good faith, has offered and made available to me an opportunity to seek necessary medical treatment and/or observation.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above described injury.

_____
Employee's Signature

_____
Date

_____
Employee Representative/Witness